Attachment 22

Iowa Emergency Medical Care Provider Scope of Practice

Iowa Department of Public Health

BUREAU OF EMERGENCY MEDICAL SERVICES

Iowa Emergency Medical Care Provider Scope of Practice

April 2013

"Promoting and Protecting the Health of Iowans through EMS"

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Iowa Law Enforcement Emergency Care Provider (ILEECP)

This EMS provider level is for Iowa peace officers who successfully complete a program of training that uses the department approved curriculum and have successfully completed the required testing as outlined in IAC 641--139. Individuals certified at this level will have a certification number identified with the letter "L". ILEECP certificates expire on July 1. Recertification requirements include four hours of approved continuing education.

Scope of Practice for ILEECP Certified Providers

AIRWAY / VENTILATION / OXYGENATION
Skill
Bag-Valve-Mask (BVM)
Cricoid Pressure (Sellick)
Head-tilt/chin-lift
Jaw-thrust
Jaw-thrust - Modified (trauma)
Mouth-to-Barrier
Mouth-to-Mask
Mouth-to-Mouth
Mouth-to-Nose
Mouth-to-Stoma
Obstruction – Manual

CARDIOVASCULAR / CIRCULATION
Skill
Cardiopulmonary Resuscitation (CPR)
Defibrillation – Automated / Semi-Automated (AED)
Hemorrhage Control – Direct Pressure
Hemorrhage Control – Pressure Point
Hemorrhage Control – Tourniquet

IMMOBILIZATION
Skill
Spinal Immobilization – Manual Stabilization
Splinting – Manual

MISCELLANEOUS
Skill
Assisted Delivery (child-birth)

Basic Level Emergency Medical Care Providers

First Responder (1979) (FR)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1979 FR national standard curriculum (NSC) and have successfully completed the testing requirements. Individuals certified at this level have a certification number identified with the letter "F". Initial certification at this level is no longer available. **THIS LEVEL IS NOT ELIGIBLE FOR TRANSITION.**

First Responder – Defibrillation (FR-D)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1979 FR national standard curriculum and the AED supplemental curriculum, and have successfully completed the testing requirements. Individuals certified at this level have a certification number identified with the letter "G." Initial certification at this level is no longer available. **THIS LEVEL IS NOT ELIGIBLE FOR TRANSITION.**

First Responder (1996) (FR)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1979 FR national standard curriculum (NCS) and completed the Iowa Transition Curriculum, or the 1996 FR NSC with the Iowa Supplemental curriculum, and have successfully completed the testing requirements. Individuals certified at this level have a certification number identified with the letter "F". **THIS LEVEL MUST TRANSITION DURING THE 2013 OR 2014 RENEWAL CYCLE.**

Emergency Medical Technician – Ambulance (EMT-A)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1984 EMT-A national standard curriculum (NSC) and have successfully completed the department's testing requirements. Individuals certified at this level have a certification number identified with the letter "A." Initial certification at this level is no longer available. **THIS LEVEL IS NOT ELIGIBLE FOR TRANSITION.**

Emergency Medical Technician – Defibrillation (EMT-D)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1984 EMT-A national standard curriculum (NSC) and the AED supplemental curriculum, and have successfully completed the department's testing requirements. Individuals certified at this level have a certification number identified with the letter "D". Initial certification at this level is no longer available. **THIS LEVEL IS NOT ELIGIBLE FOR TRANSITION.**

Emergency Medical Technician – Basic (EMT-B)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1996 EMT-B national standard curriculum (NSC) and the Iowa supplemental curriculum, and have successfully completed the department's testing requirements. Individuals certified at this level have a certification number identified with the letter "B." **THIS LEVEL MUST TRANSITION DURING THE 2014 OR 2015 RENEWAL CYCLE.**

LEVELS BEGINNING AUGUST 1, 2011

Emergency Medical Responders (EMR)

This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 2005 National Education Standards for the EMR and successfully completed the testing requirements or completed the FR to EMR transition requirement. Individuals certified at this level have a certification number identified with the letters "EMR."

The primary focus of the EMR is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. EMRs function as part of a comprehensive EMS response, under medical oversight. EMRs perform basic interventions with minimal equipment.

Emergency Medical Technician (EMT)

This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 2005 National Education Standards for the EMT and successfully completed the testing requirements, transition from EMT-I 1985+, or completed the EMT-B to EMT transition requirements. Individuals certified at this level have a certification number identified with the letters "EMT".

The primary focus of the EMT is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. EMTs function as part of a comprehensive EMS response, under medical oversight. EMTs perform interventions with the basic equipment typically found on an ambulance. The EMT is a link from the scene to the emergency health care system.

Airway and Breathing								
SKILL	FR 79	G	FR 96	**EMR**	A	D	B	**EMT**
Airway - Manual	X	X	X	**X**	X	X	X	**X**
Airway-Oral			X	**X**	X	X	X	**X**
Airway-Nasal			X		X	X	X	**X**
Airway- Multi-Lumen			X				X	
Airway-Esophageal/Tracheal			X				X	
CPAP								**+**
Obstruction - Manual	X	X	X	**X**	X	X	X	**X**
Oxygen Delivery			X	**X**	X	X	X	**X**
Oxygen Delivery-Humidified			X		X	X	X	**X**
Sellick's Maneuver	X	X	X	**X**	X	X	X	**X**
Suctioning - Upper Airway	X	X	X	**X**	X	X	X	**X**
Ventilations - Bag Valve	X	X	X	**X**	X	X	X	**X**
Ventilations – via Mouth	X	X	X	**X**	X	X	X	**X**
Ventilations- Manually Triggered					X	X	X	**X**
Ventilator - Automatic Transport							X	**X**

+ Additional training and medical director approval required

Assessment								
SKILL	FR 79	G	FR 96	**EMR**	A	D	B	**EMT**
Blood Glucose Monitor							X	**+**
Blood Pressure	X	X	X	**X**	X	X	X	**X**
Pulse Oximetry	X	X	X	**+**	X	X	X	**X**

+ Additional training and medical director approval required

Pharmacological Intervention								
SKILL	FR 79	G	FR 96	**EMR**	A	D	B	**EMT**
Autoinjector- Self/Peer Rescue				**X**			X	**X**
Autoinjector - Epinephrine							X	**+**
OTC Medications			X		X	X	X	**X**
Patient Assisted Meds (including Epi-pen)							X	**X**
Buccal								**1**
Oral				**++**				**2**
IV Fluid Infusion							X	

+ Additional training and medical director approval required
++ EMRs may administer aspirin with additional training and medical director approval

EMT DRUG LIST

1 Buccal	Oral Glucose
2. Oral	Glucose/Aspirin

Emergency Trauma Care								
SKILL	FR 79	G	FR 96	**EMR**	A	D	B	**EMT**
Cervical Stabilization - Manual	X	X	X	**X**	X	X	X	**X**
Cervical Stabilization – C-Collar	X	X	X		X	X	X	**X**
Extremity Stabilization - Manual	X	X	X	**X**	X	X	X	**X**
Extremity Splinting					X	X	X	**X**
Eye Irrigation	X	X	X	**X**	X	X	X	**X**
Hemorrhage Control	X	X	X	**X**	X	X	X	**X**
PASG					X	X	X	**X**
Spinal Immobilization					X	X	X	**X**
Tourniquet	X	X	X		X	X	X	**X**

Medical/Cardiac Care								
SKILL	FR 79	G	FR 96	**EMR**	A	D	B	**EMT**
Assisted Delivery	X	X	X	**X**	X	X	X	**X**
CPR - Manual	X	X	X	**X**	X	X	X	**X**
CPR - Mechanical					X	X	X	**X**
Defibrillator - Automated	X	X	X	**X**	X	X	X	**X**

Advanced Level Emergency Medical Care Providers

Emergency Medical Technician – Intermediate (EMT-I)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1985 EMT-I national standard curriculum (NSC) or the Iowa EMT-I (2000) curriculum, and have successfully completed the department's testing requirements. Individuals certified at this level have a certification number identified with the letter "I." **THIS LEVEL MAY TRANSITION TO THE AEMT LEVEL BEFORE APRIL 1, 2016.**

Iowa Emergency Medical Technician – Paramedic (EMT-P)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1985 EMT-P national standard curriculum (NSC), or the 1999 EMT-I NSC curriculum, and have successfully completed the department's testing requirements. Individuals certified at this level have a certification number identified with the letter "P." **THIS LEVEL MAY TRANSITION TO THE PARAMEDIC LEVEL BEFORE APRIL 1, 2018.**

Paramedic Specialist (PS)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 1985 EMT-P national standard curriculum (NSC), plus documentation of completion of the objectives to the 1998 EMT-P NSC, or completed the 1998 EMT-P NSC, and have successfully completed the department's testing requirements. Individuals certified at this level have a certification number identified with the letters "PS." **THIS LEVEL MUST TRANSITION BY THE 2014 OR 2015 RENEWAL PERIOD**

LEVELS BEGINNING AUGUST 1, 2011

Advanced Emergency Medical Technician (AEMT)
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 2005 National Education Standards for the AEMT or completed the EMT-I to AEMT transition requirements and successfully completed the testing requirements. Providers certified as EMT-P may transition to AEMT. Individuals certified at this level have a certification number identified with the letters "AEMT."

The primary focus of the AEMT is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. AEMTs function as part of a comprehensive EMS response, under medical oversight. AEMTs perform interventions with the basic and advanced equipment typically found on an ambulance. The AEMT is a link from the scene to the emergency health care system.

Paramedic
This EMS provider level identifies individuals who have successfully completed a program of training that used, as a minimum, the 2005 National Education Standards for the Paramedic or completed the EMT-P to Paramedic transition requirements and successfully completed the testing requirements. Providers certified at the PS level may transition by meeting the PS to Paramedic Transition Requirements. Individuals certified at this level have a certification number identified with the letters "PM."

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system.

ENDORSEMENT LEVEL

Critical Care Paramedic (CCP)
This EMS provider endorsement identifies individuals who hold a valid Iowa PS or Paramedic certification and have successfully completed an Iowa approved Critical Care Paramedic program. Individuals holding a valid endorsement as a CCP and working for an approved CCP transporting service may perform CCP skills listed below during intra-facility critical care transport (CCT).

Airway and Breathing						
SKILL	EMT-I	**AEMT**	P	PS	**PARA**	CCP
Airway - Manual	X	**X**	X	X	**X**	X
Airway-Nasal	X	**X**	X	X	**X**	X
Airway-Oral	X	**X**	X	X	**X**	X
Airway- Multi-Lumen	X	**X**	X	X	**X**	X
Airway-Esophageal/Tracheal	X	**X**	X	X	**X**	X
BiPAP/CPAP		+	CPAP	CPAP	**X**	X
Bridge Airway Devices			X	X	**X**	X
Capnography/$ETCO_2$			X	X	**X**	X
Chest Tube Placement-Assist						X
Chest Tube-Monitoring					**X**	X
Crichothyrotomy - Percutaneous			X	X	**X**	X
Crichothyrotomy - Surgical						X
Endotracheal Intubation- Nasal/Oral			X	X	**X**	X
Endotracheal Intubation- Retrograde						X
Gastric Decompression - NG or OG tube			X	X	**X**	X
Needle Chest Decompression			X	X	**X**	X
Obstruction - Direct Laryngoscopy			X	X	**X**	X
Obstruction - Manual	X	**X**	X	X	**X**	X
Oxygen Delivery (including humidified)	X	**X**	X	X	**X**	X
PEEP Therapeutic (>6 cm H_2O pressure)				X	**X**	X
Sellick's Maneuver	X	**X**	X	X	**X**	X
Suctioning - Upper Airway	X	**X**	X	X	**X**	X
Ventilations - Bag Valve	X	**X**	X	X	**X**	X
Ventilations – via Mouth	X	**X**	X	X	**X**	X
Ventilations- Manually Triggered	X	**X**	X	X	**X**	X
Ventilator - Automatic Transport	X	**X**	X	X	**X**	X
Ventilator - Enhanced						X
Suctioning - Tracheobronchial		**X**	X	X	**X**	X

+ CPAP may be used with additional training and medical director approval required

Assessment						
SKILL	EMT-I	**AEMT**	P	PS	**PARA**	CCP
Blood Chemistry Analysis					**X**	X
Blood Glucose Monitor	X	**X**	X	X	**X**	X
Blood Pressure	X	**X**	X	X	**X**	X
Blood Sampling - Arterial						X
Blood Sampling - Capillary Tube	X		X	X	**X**	X
Blood Sampling - Venous	X		X	X	**X**	X
Central Line Monitoring					**X**	X
EKG - Multi lead (interpretive)				X	**X**	X

Assessment (cont)						
EKG - Single lead (interpretive)			X	X	**X**	X
Hemodynamic Monitoring						X
ICP Monitoring						X
Pulse Oximetry	X	**X**	X	X	**X**	X

Pharmacological Intervention						
SKILL	EMT-I	AEMT	P	PS	**PARA**	CCP
Autoinjector- Self/Peer Rescue	X	**X**	X	X	**X**	X
Autoinjector - Epinephrine	X	**X**	X	X	**X**	X
OTC Medications	X	**X**	X	X	**X**	X
Patient Assisted Meds	X	**X**	X	X	**X**	X
Aerosolized/Nebulized		**1**	X	X	**X**	X
Buccal		**2**	X	X	**X**	X
Endotracheal tube			X	X	**X**	X
Inhaled - Self administered		**3**	X	X	**X**	X
Intramuscular		**4**	X	X	**X**	X
Intranasal			X	X	**X**	X
Intravenous push		**5**	X	X	**X**	X
Intravenous piggyback			X	X	**X**	X
Nasogastric			X	X	**X**	X
Oral		**6**	X	X	**X**	X
Rectal			X	X	**X**	X
Subcutaneous		**7**	X	X	**X**	X
Sublingual		**8**	X	X	**X**	X
Arterial Line - Monitoring						X
Blood Administration			X	X	**X**	X
Central Line Access	+	**+**	+	+	**X**	X
IO Insertion		**X**	X	X	**X**	X
IV Fluid Infusion	X	**X**	X	X	**X**	X
Peripheral IV Insertion	X	**X**	X	X	**X**	X
Thrombolytic Administration				X	**X**	X
Umbilical Initiation				X		X

+ Additional training and medical director approval required

AEMT DRUG LIST

1 Aerosolized/Nebulized	Beta agonist
2 Buccal	Oral Glucose
3 Inhaled - Self administered	Nitrous Oxide
4 Intramuscular	Nalaxone/Epinephrine/Glucagon
5 Intravenous push	Nalaxone/Dextrose/Glucagon
6. Oral	Glucose/Aspirin
7. Subcutaneous	Epinephrine/Glucagon
8. Sublingal	Nitroglycerin

Emergency Trauma Care						
SKILL	EMT-I	**AEMT**	P	PS	**PARA**	CCP
Cervical Stabilization - Manual	X	**X**	X	X	**X**	X
Extremity Stabilization - Manual	X	**X**	X	X	**X**	X
Extremity Splinting	X	**X**	X	X	**X**	X
Eye Irrigation	X	**X**	X	X	**X**	X
Eye Irrigation - Morgan Lens			X	X	**X**	X
Hemorrhage Control	X	**X**	X	X	**X**	X
PASG	X	**X**	X	X	**X**	X
Spinal immobilization	X	**X**	X	X	**X**	X
Tourniquet	X	**X**	X	X	**X**	X

Medical/Cardiac Care						
SKILL	EMT-I	**AEMT**	P	PS	**PARA**	CCP
Assisted Delivery	X	**X**	X	X	**X**	X
Cardioversion			X	X	**X**	X
Carotid Massage			X	X	**X**	X
CPR – Manual/Mechanical	X	**X**	X	X	**X**	X
Defibrillation - Manual			X	X	**X**	X
Defibrillator - Automated	X	**X**	X	X	**X**	X
Transcutaneous Pacing			X	X	**X**	X
Urinary Catheterization			X	X		X

Attachment 23

Iowa EMS System Standards

IOWA EMS SYSTEM STANDARDS

"What Every Iowan Can Expect From Emergency Medical Services"

Iowa EMS System Standards
Overview

The Iowa EMS System Standards are a change initiative that provides a consistent and accountable approach to promoting and protecting the health of Iowans through EMS. The standards describe, in a tempered and realistic manner, the minimum infrastructure (county) and EMS services that all Iowans can reasonably expect from Emergency Medical Services no matter where they live in the state. Utilizing the Iowa EMS System Standards will attain the goal of designing and implementing an integrated, measurable, sustainable state wide EMS System.

Some of the benefits of implementing and utilizing the Iowa EMS System Standards are:

- Creates an "inclusive system" where all EMS providers, service programs and other health care professions participate in attaining identifiable, measurable minimum standards that will bring consistency to EMS practice. "Standards are statements that define the performance expectations that must be in place for EMS to assure high-quality patient care services."
- Accountability to the public
- Consistent basic(minimal)EMS infrastructure across the state
- Identifying expected range of performance and what is needed to support that performance(capacity)
- Professionalization of EMS
- Increased visibility and understanding of the EMS system by the general public
- Supports ongoing evaluation and improvement of the EMS system
- Increased integration of EMS into the public health system
- Strengthens existing local, county, regional EMS organizations
- Enables proactive initiatives for required law/rule additions or changes
- Enables proactive initiatives for standardized funding mechanisms

Background:

In October, 2006 the Emergency Medical Services Advisory Council (EMSAC) was approached by the Bureau of EMS to support a change initiative involving EMS system standards. Discussions lead to a motion that "the Bureau should continue to develop draft standards and appoint partners to assist." A group of 26 to 30 individuals were invited to participate through monthly meetings, in the development of a first draft version of minimum Iowa EMS System Standards. Progress reports were given to EMSAC in January and April, with the first draft version delivered to EMSAC in July, 2007.

The stakeholder group reviewed eight areas of EMS system development. These were:

- System Administration
- Staffing/Training
- Communications
- Response/Transportation
- Facilities/Critical Care
- Data collection/System Evaluation
- Public Information/Education
- Disaster Medical Response/Planning

In addition, while developing the minimum Iowa EMS System Standards, the stakeholder group used some guiding principles:

- Define basic minimum services and infrastructure that every EMS system should have in place
- Use clear, concise language that is easily understood by both the EMS/health care community and the general public
- Minimum standards should be measurable
- Keep in mind the principles of the national and state "EMS Agenda for the Future"

Next Steps:
The first draft version of the Iowa EMS System Standards was received by the EMS Advisory Council on July 11th, 2007. Further input from EMS stakeholders from across the state will be gathered during scheduled presentations from July through September, 2007.

The gathered public comments, public comment period ended September 21, 2007, for the Iowa EMS System Standards have been posted to the Bureau's website.

A final draft version of the minimum Iowa EMS System Standards was presented to EMSAC October, 2007 and approved. This version of the Iowa EMS System Standards was approved and a program to pilot the standards was developed. The pilot program was designed to identify what is already in place to meet the standards, what is not in place to meet the standards, what measures are needed to meet the standards and what are the costs to meet and maintain the standards. The pilot program began in April, 2008 and ended in March, 2010 with final reports due April 30, 2010.

The pilot project consisted of four Iowa counties: Calhoun Co. population <20,000; Des Moines Co. population>20,000; Jones Co. population >20,000; Woodbury Co. population >50,000. These counties evaluated the use of the draft Iowa EMS System Standards to establish county wide EMS systems. During the pilot project, the four counties have met with the original stakeholder group three times (January 2009, August 2009, December 2009) to discuss results in terms of common themes, barriers, successes and best practices. A fourth meeting was held June 18, 2010 to discuss the results of the final project reports and determine what steps need to be taken in the near future. A third

draft of the EMS System Standards was developed from the changes, deletions and additions suggested in the final reports. A fifth meeting of the stakeholder group/pilot project counties was held August 3, 2010 to develop the final version of the EMS System Standards.

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The final goal will be the development of a "Roadmap" to address issues of accomplishing and maintaining system standards, funding initiatives and law/rule additions/changes needed.

Iowa EMS System Standards
Stakeholder Committee

Rick Benson	Council Bluffs	Steve Vandenbrink	Decorah
Gary Brown	Woodbury Co.	Dave Wilson	Cedar Rapids
Jeffrey Call	Bloomfield		
John Cockrell	Burlington		
Thomas Colthurst	Des Moines Co.		
Thomas Craighton	Hampton		
John Crouch	Des Moines Co.		
Larry Cruchelow	Carroll		
Jeff Doerr	Dubuque		
John Fiedler	West Des Moines		
Dan Frank	Mediapolis		
Sheila Frink	Anamosa		
Gene Haukoos	Estherville		
Trica Holden	Manly		
Kerrie Hull	Rockwell City		
Brian Jacobsen	Davenport		
Jerry Johnston	Mt. Pleasant		
Sarah LaBrune-Jongeling	Woodbury Co.		
Don Lucas	Mitchellville		
Dave Luers	Burlington		
Tim Malchow	Monticello		
Dr. Dennis Mallory	Toledo		
Laura Malone	Iowa Hospital Association		
Jim Mehaffy	Mediapolis		
Dave Miller	Harlan		
Angie Moore	Waukee		
Marty Parbs	Marengo		
Frank Prowant	Ankeny		
Kristi Quinn	Woodbury Co.		
Doug Reed	Oakland		
Ray Rex	Fairfield		
Matt Ringgenberg	Lake City		
Randy Ross	Onawa		
Julie K. Scadden	Schaller		
Scott Slough	Greenfield		
Dave Springer	Springfield, Ill.		
Terry Stecker	Sioux City		
Jim Stephen	Mt. Pleasant		
Dave Tice	Charles City		
Maile A. Timm	Story City		
Thomas Toycen	Mt. Vernon		
Matt Trexel	Des Moines Co.		

Glossary of Terms

ALS-Interventions identified at the EMT-I, AEMT, EMT-P, PS or Paramedic level

Ambulance-As defined by rule: 641-132.1 (147A) Definitions. "Ambulance" means any privately or publicly owned ground vehicle specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated."

Audit-Review of a process

BLS-Interventions identified at the FR, EMR, EMT-B or EMT level

Certification- State of Iowa EMS Certification

CQI- As defined by rule: 641-132.1 (147A) Definitions. "Continuous quality improvement (CQI)" means a program that is an ongoing process to monitor standards at all EMS operational levels including the structure, process, and outcomes of the patient care event." This can change to fit the system.

Credentialing-The process for ensuring knowledge, skills and ability to participate within the system.

EMD (Emergency Medical Dispatch) - "Emergency Medical Dispatching" shall mean the reception, evaluation, processing, provision of dispatch life support, management of requests for emergency medical assistance, and participation in ongoing evaluation and improvement of the emergency medical dispatch process. This process includes identifying the nature of the request, prioritizing the severity of the request, dispatching the necessary resources, providing medical aid and safety instructions to the callers and coordinating the responding resources as needed but does not include call routing per se.

EMS- As defined by rule: 641-132.1 (147A) Definitions. "Emergency medical services" or "EMS" means an integrated medical care delivery system to provide emergency and non-emergency medical care at the scene or during out-of-hospital patient transportation in an ambulance."

EMS System- means an integrated medical care delivery system to provide emergency and non-emergency medical care at the scene or during out-of-hospital patient transportation in an ambulance." The system shall be no smaller than a county.

First Responder / EMR-State of Iowa EMS provider at least equipped with an AED

Medical Director- As defined by rule: 641-132.1 (147A) Definitions. "Medical director" means any physician licensed under Iowa Code chapter 148, 150, or 150A who shall be responsible for overall medical direction of the service program and who has completed a medical director workshop, sponsored by the department, within one year of assuming duties."

NIMS- National Incident Management System.

Rural-Non-Urban areas

System Participant- Service or Agency recognized by the Bureau of EMS and the EMS System

Urban-Communities within a county with a population greater than 10,000

Wilderness-Area without infrastructure

System Organization and Management

1.01 System Administration: EMS System Structure

MINIMUM STANDARD: *Each COUNTY shall make provisions for emergency medical services treatment and transport for all within the county, to meet Iowa EMS System Standards. Each county shall be responsible for the approval of services within their EMS system based on a needs assessment.*

1.02 System Administration: EMS System Mission

MINIMUM STANDARD: *The EMS system shall have a written vision and mission statement and will meet at least annually to engage in strategic planning. The EMS system shall have a formal organization chart that identifies who is responsible for implementing the Iowa EMS system standards.*

1.03 System Administration: Public Impact

MINIMUM STANDARD: *The EMS system shall have a mechanism to seek and obtain appropriate consumer and health care provider input.*

1.04 System Administration: Medical Director / Medical Direction

MINIMUM STANDARD: *The EMS system shall have an active medical director or active Medical Director system. Systems with multiple medical directors shall form a medical advisory council to support the system medical director.*

a) Each EMS system shall develop written medical direction policies, procedures, and/or protocols for all transporting/non-transporting EMS services including, but not limited to:

- *Triage*
- *Treatment*
- *Medical dispatch protocols*
- *Transport/tiered response/provision of ALS care*
- *On-scene treatment times*
- *Transfer of emergency patients*
- *Standing orders*
- *Hospital contact*
- *On-scene physicians and other medical personnel*

b) Each EMS system shall develop and utilize a medical control plan that shall have on-line medical direction available that is provided by a physician or physician designee or supervising physician. The plan shall also identify the role

of hospitals, alternative medical control and the roles, responsibilities, and relationships of out-of-hospital providers.

c) *The EMS system, in conjunction with the county medical examiner, shall develop a policy regarding determination of death, including deaths at the scene of apparent crimes.*

d) *The EMS system shall ensure that providers have a mechanism for reporting child abuse, and dependant adult abuse.*

e) *The EMS medical direction, in conjunction with transferring facilities, shall establish policy and procedures for out of hospital medical personnel during inter-facility transfers.*

1.05 System Administration: Development & Review Plan

MINIMUM STANDARD: *The EMS system shall develop an EMS System Plan, based on community need and utilization of appropriate resources, and shall submit it to the EMS Bureau. The plan shall:*

a) *Assess how the current system meets these guidelines.*

b) *Identify system needs for patients within each of the targeted clinical categories/special populations, and*

c) *Provide a methodology and timeline for meeting these needs.*

d) *Have a continuous quality improvement and evaluation process that is approved by the EMS System.*

e) *Provide for review and monitoring of EMS system operations.*

f) *Provide for an annual update to the EMS System Plan and submit the plan to the EMS Bureau. The update shall identify progress made in plan implementation and changes to the planned system design.*

1.06 System Administration: Advanced Life Support (ALS)

MINIMUM STANDARD: *The EMS system shall have a provision for ALS care.*

1.07 System Administration: Inventory of Resources

MINIMUM STANDARD: *The EMS system shall develop in coordination with county EMA a detailed inventory of EMS resources (e.g., personnel, vehicles, and facilities) within its area and, at least annually, shall update this inventory.*

1.08 System Administration: System Participants

MINIMUM STANDARD*: The EMS system shall ensure that system participants conform to their assigned EMS system roles and responsibilities.*

1.09 System Administration: Policy & Procedures Manual

MINIMUM STANDARD*: The EMS system shall develop policies and procedures that implement the Iowa EMS system standards. The system shall ensure that the manual is available to all EMS system providers (including public safety agencies, ambulance services, non-transport services, air-medical services, and hospitals) within the system. The EMS system shall have a mechanism to review, monitor and ensure compliance with system policies at least annually.*

1.10 System Administration: Funding Mechanism

MINIMUM STANDARD*: The EMS system shall identify funding mechanisms that are sufficient to ensure its continued operation and shall maximize use of its fiscal resources.*

Staffing and Training

2.01 Staffing: Assessment of Needs

MINIMUM STANDARD*: The EMS system shall, at least annually, assess staffing and training needs.*

2.02 Staffing: Personnel

MINIMUM STANDARD*: The EMS system shall have mechanisms to assure certification.*

a) *The EMS system shall have a process for providers to identify and notify the Bureau of EMS, as required by rule, of occurrences that impact EMS certification.*

b) *Services within the EMS system shall have a plan in place to credential personnel as applicable to EMS certification levels and local protocol as authorized by the medical director.*

2.03 Staffing: Dispatch Training

MINIMUM STANDARD*: Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) shall be trained and/or certified using an approved program.*

2.04 Staffing: Non transport

MINIMUM STANDARD*: The EMS System shall ensure at least one person on each non-transporting EMS response shall be a currently certified EMS provider. Public safety agencies and industrial first-aid teams shall be utilized in accordance with EMS system policies.*

2.05 Staffing: Transport

MINIMUM STANDARD*: The EMS system shall ensure that all transporting units meet state personnel minimum staffing requirements.*

2.06 Training: Hospital Communications

MINIMUM STANDARD: *The EMS system shall ensure all hospital/alternative base station personnel who provide medical direction to out of hospital personnel shall be knowledgeable about EMS system policies and procedures.*

Communications

3.01 Communications: Plan

MINIMUM STANDARD*: The EMS system shall develop a plan to coordinate EMS communications. The plan shall specify the medical communications capabilities of emergency medical transport vehicles; non-transporting agencies; and system participants.*

3.02 Communications: Equipment

MINIMUM STANDARD*: The EMS system shall ensure system participants have two-way communications equipment that complies with the EMS communications plan and that provides for dispatch and ambulance-to-hospital communication.*

a) *The EMS system shall ensure all hospitals within the EMS system shall (where physically possible) have the ability to communicate with each other by two-way communications according to the EMS plan.*

b) *The EMS system shall ensure system participants involved in inter-facility transfers have the ability to communicate with both the sending and receiving facilities.*

3.03 Communications: Dispatch

MINIMUM STANDARD*: The EMS system shall ensure all emergency medical transport vehicles, where physically possible (based on geography and technology), shall have the ability to communicate with a single dispatch center or disaster communications command post.*

a) *The EMS system shall review, at least annually, communications linkages (inter-operability) among providers (out of hospital and hospital) in its jurisdiction and recommend needed changes for their capability to provide service in the event of multi-casualty incidents and disasters.*

b) *The EMS system shall have a functionally integrated dispatch with system-wide emergency management coordination, using standardized communications frequencies.*

c) *The EMS system may establish an emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.*

3.04 Communications: 911 Coordination

MINIMUM STANDARD*: The EMS system shall seek to have an active member appointed to the county 911 commission in order to participate in ongoing planning and coordination of the enhanced 9-1-1 system*

3.05 Communications : Education

MINIMUM STANDARD*: The EMS system shall be involved in public education regarding system access.*

Response & Transportation

4.01 Response & Transportation: Service Area

MINIMUM STANDARD: *The EMS system shall, in coordination with neighboring EMS Systems, determine the emergency medical service response areas, to ensure the most appropriate response.*

4.02 Response & Transportation: Monitoring

MINIMUM STANDARD: *The EMS system shall monitor compliance with appropriate code, rules, policies and procedures.*

4.03 Response & Transportation: Contingency Response / Mutual Aid

MINIMUM STANDARD: *The EMS system shall have contingency plans and assure the development of mutual aid agreements to provide for emergent and non-emergent response during increased system volume.*

4.04 Response & Transportation: Response Time Standards

MINIMUM STANDARD: *Each EMS system shall adopt the following standards for emergent responses. These standards shall take into account the total time from dispatch to arrival of the responding unit at the scene, including all dispatch intervals and driving time.* Emergency medical service areas (response zones) shall be designated so that, for eighty percent of emergent responses:

- The response time for first responders does not exceed:
  Urban—5 minutes
  Rural—15 minutes
  Wilderness—as quickly as possible

- The response time for an ambulance (not functioning as the first responder) does not exceed:
  Urban-8 minutes
  Rural- 20 minutes
  Wilderness—as quickly as possible

- The response time for an advanced life support does not exceed:
  Urban-8 minutes
  Rural-20 minutes

4.05 Response & Transportation: Air - Medical Services

MINIMUM STANDARD: *The EMS system shall have a process for identifying specialty air-medical transport services and shall develop policies and procedures regarding:*

- *Requesting of air-medical service*
- *Determination of patient destination*
- *Orientation of pilots and medical flight crews to the EMS system*
- *Addressing and resolving formal complaints*

4.06 Response & Transportation: Special Vehicles

MINIMUM STANDARD: *Where applicable, the EMS system shall identify the availability and staffing of specialty vehicles such as all-terrain vehicles, snowmobiles, water rescue and transportation vehicles.*

4.07 Response & Transportation: Multi-casualty Disaster Response

MINIMUM STANDARD: *The EMS system shall develop multi-casualty response plans and procedures that are consistent with NIMS guidelines.*

Facilities/Critical Care

5.01 Facilities: Assessment of Capabilities

MINIMUM STANDARD: *The EMS system shall assess, at least annually, the EMS-related capabilities of acute care facilities in its service area***.**

5.02 Facilities: Triage, Transport & Transfer Protocols

MINIMUM STANDARD: *The EMS system shall assist hospitals with coordination of pre-hospital triage, transport and transfer destination protocols and agreements.*

5.03 Facilities: Mass Casualty Management

MINIMUM STANDARD: *The EMS system shall assist hospitals and acute care facilities with planning and preparation for mass casualty management, including procedures for coordinating hospital communications, evacuation, and patient flow.*

5.04 Facilities : Trauma Care system

MINIMUM STANDARD: *The EMS system shall monitor the use of the Out of Hospital Trauma Triage Destination Decision Protocol in cooperation with their Trauma Care Facility.*

5.05 Trauma Care Facility Verification

MINIMUM STANDARD*: The EMS system shall participate in the trauma verification process.*

Data Collection/System Evaluation

6.01 System Evaluation: Continuous Quality Improvement Program

MINIMUM STANDARD: *The EMS system shall establish an EMS CQI program to evaluate the response to emergency medical incidents and the care provided to specific patients. The program shall address the total EMS system, including all pre-hospital provider agencies and hospitals. It shall address compliance with policies, procedures and protocols and identification of preventable morbidity and mortality and document resolution of deficiencies found.*

6.02 System Evaluation: Out of hospital Care Audits

MINIMUM STANDARD: *The EMS system shall conduct audits of out-of-hospital care, including both system response and clinical aspects. The EMS system should have a mechanism to link pre-hospital records with dispatch, emergency department, in-patient, and discharge records.*

6.03 System Evaluation: Medical Dispatch

MINIMUM STANDARD: *The EMS system shall have a mechanism, in cooperation with the dispatch center, to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of pre-arrival/post dispatch directions.*

6.04 System Evaluation: System Design Evaluation

MINIMUM STANDARD: *The EMS system shall establish an evaluation program to evaluate EMS system design and operations, including system effectiveness at meeting community needs, appropriateness of guidelines and standards, prevention strategies that are tailored to community needs, and assessment of resources needed to adequately support the system. This shall include structure, process and outcome evaluations.*

6.05 System Evaluation: Provider/Service Participation

MINIMUM STANDARD: *The EMS system shall have the resources to require provider/service participation in the system wide evaluation programs.*

6.06 System Evaluation: Reporting

MINIMUM STANDARD: *The EMS system shall, at least annually, report on the results of its evaluation of EMS system design and operations to their governing agency, local services, and other stakeholders.*

6.07 Data Collection: Pre-hospital Record

MINIMUM STANDARD: *Pre-hospital records for all patient responses shall be completed and forwarded to appropriate agencies as defined by Iowa Administrative Code.*

6.08 Data Collection: Data Management System

MINIMUM STANDARD: *The EMS system should participate in an integrated data Management system that includes system response and clinical (pre-hospital, hospital and public health) data.*

Public Information and Education

7.01 Public Information: Materials

MINIMUM STANDARD: *The EMS system shall promote the development and dissemination of information materials for the public that address:*

- *Understanding of EMS system design and operation*
- *Proper access to the system*
- *Self help (e.g. CPR, first aid, etc)*
- *Patient and consumer rights as they relate to the EMS system*
- *Health and safety habits as they relate to the prevention and reduction of health risks in target areas*
- *Appropriate utilization of emergency departments*
- *Promote injury control and preventive medicine*

7.02 Public Information: Disaster Preparedness

MINIMUM STANDARD: *The EMS system, in conjunction with the local office of emergency management (EMA) shall promote citizen disaster preparedness activities.*

7.03 Public Information: First Aid and CPR Training

MINIMUM STANDARD: *The EMS system shall promote the availability of first aid and CPR training for the general public.*

Disaster Medical Response

8.01 Disaster Medical Response: Planning

MINIMUM STANDARD: *The EMS system shall participate with their local EMA and Public Health to develop plans, procedures and policy to respond effectively to the medical needs created by disasters.*

8.02 Disaster Medical Response: Response Plans/Review

MINIMUM STANDARD: *The EMS System shall have medical response plans and procedures for disasters which shall be applicable to incidents caused by a variety of hazards.*

a) The EMS system shall annually review the disaster medical response plans.

b) The Iowa Office of Home Land Security and Emergency Management Division multi-hazard functional plan should serve as the model for the plans.

8.03 Disaster Medical Response: Emergency Operation Centers

MINIMUM STANDARD: *The EMS system shall participate with their local EMA in the development and exercise of a plan for activation, operation and deactivation of the emergency operation center.*

8.04 Disaster Medical Response: Hazardous Materials Training

MINIMUM STANDARD: *The EMS System shall ensure all EMS providers be properly trained and equipped for response to hazardous materials incidents, as determined by their system role and responsibilities.*

8.05 Disaster Medical Response: Plan Participation (ICS)

MINIMUM STANDARD: *The EMS system shall ensure that system participants are trained to implement the incident command system.*

8.06 Disaster Medical Response: Inventory

MINIMUM STANDARD: *The EMS system shall develop and maintain an inventory of the disaster medical resources that are available for deployment, and update annually.*

8.07 Disaster Medical Response: Continuation of Service

MINIMUM STANDARD: *The EMS system shall develop plans to ensure continuation of EMS services during disasters to the extent possible.*

8.08 Disaster Medical Response: Hospital Plans

MINIMUM STANDARD: *The EMS system shall encourage hospitals to ensure that their plans for internal and external disasters are fully integrated with the system's medical response plan(s).*

IOWA EMS SYSTEM STANDARDS

Frequently Asked Questions

For EMS Providers

IDPH & the Bureau of EMS are just trying to take my department away from me.	Iowa EMS System Standards was debated, written and applied in investigative studies, by over 40 EMS and allied professionals. Iowa EMS Systems Standards recognizes "…advancing technology and increasing national standards for training and certification are increasing the standard of patient care[i]," which results in an immense administrative burden for volunteer services. The effectiveness of reducing administrative burden was illustrated when one of the pilot studies was approached by two nearby EMS services, to ask permission to reproduce several of the "system documents and policies."
Things are just fine (in my jurisdiction), so why are we even talking about Iowa EMS System Standards?	The current system is working in many places, both in Iowa and nationally, but there is a high potential for service failure in some areas. In 1996, the EMS Agenda for the Future by published by the National Highway Traffic Safety Administration (NHTSA) and the Health Resources and Services Administration (HRSA) noted this weakness among many others, and began seeking a solution. In 2005, the Iowa Department of Public Health, Bureau of EMS published the Iowa Agenda for the future which focused on how Iowans would be affected by the conclusions of the 1996 NHTSA report. In the summary of this document, it is noted "Health care is changing rapidly and EMS care is no exception. Volunteerism [is struggling to] sustain a full time ambulance service…." Recent changes to federal healthcare law have abruptly reminded the public of the rapid pace of change.
Ambulance service is part of public safety and government has to provide it, don't they?	As an increasingly vital link, EMS plays a significant role in both Public Safety and health care. In Iowa, access to Emergency Medical Services, is NOT required by any government agency. The only government body, even mentioned is township trustees, who MAY elect to provide coverage. (9 IC §356.42), but many do not. Since EMS is not a required service, cities or counties may choose not to provide for EMS.
EMS doesn't need this money because they bill for reimbursement by insurance and Medicare.	The misperception is to lump EMS with ambulances, but not all EMS agencies own/operate vehicles for the purpose of patient transport. In Iowa, the majority of services are non-transport agencies that operate at the First Responder or EMT-Basic, although advanced level non transport agencies do exist. Current insurance and Medicare reimbursement practices, only reimburse transporting agencies. If more than one transport agency is involved, only one is reimbursed. Even when reimbursement occurs, it is not sufficient to cover costs, especially the cost to maintain readiness.
Why would we want the county to run our EMS?	Iowa EMS System Standards intends to involve elected officials for the specific purpose of financial accountability. Iowa EMS System Standards recommends decisions regarding policy be directed to a representative EMS board. Providing medical care and protocols shall be left to the experts (system medical director and the providers he/she is overseeing) to ensure delivery of quality patient care.

Is this an attempt to conserve money at the state level?	Iowa EMS System Standards is not a result of a budget debate, but rather a result of overcoming continuously increasing demands placed on EMS providers, service directors and medical directors in nearly all aspects of operating an EMS program. The volunteer model, which saves labor cost over a career model, is being victimized by and succumbing to these increasing demands. An unexpected discovery by the pilot studies was increased efficiency and lower cost over the current model of delivery.
Iowa EMS System Standards is just another one of those "unfunded state mandates."	Currently, EMS is primarily being paid for via tax dollars, reimbursement for services and/or donations. This will not change. Iowa EMS System Standards specifically asks for a funding mechanism that is proprietary and unique to EMS, for the purpose of being able to fiscally respond to increasing preparedness requirements as well as rapidly rising demand for and expectation of services from the public.
How long will it take me to become operational on all of these standards?	Many people view Iowa EMS System Standards as unobtainable, but based on pilot studies, the opposite was observed. Pilot studies found that they met 45%[ii] of the standards prior to making any changes. After 18 months the number of standards met doubled on average.[iii] Iowa EMS System Standards understands that local needs may be unique and in no way intends to dictate or limit how a system is designed or operated as long as the basic expectation is met, as outlined in Iowa EMS System Standards.
What is in this for me?	Within each skill level, every EMT in Iowa has to meet the same requirements to be certified. Therefore, we are all professionals and are expected to provide the same level of care to the patient, regardless of our career path. EMS services, especially their directors, will experience reductions to their paperwork, saving time. Time is better spent developing skills and communicating with other departments & agencies so when disaster strikes, your community can benefit from a quality, coordinated response. Your time is best spent doing what you are in EMS to do….. Being there to provide your neighbors with quality pre-hospital healthcare when they need it most.

[i] Iowa's EMS Agenda for the Future, September 2005

[ii] IA System Standards Project Final report pg 6; 40/80,27/80,39/80,37/80

[iii] IA System Standards Project Final report pg 6; 72/80,47/80, 58/80, 36/80

For more information, visit www.idph.state.ia.us/ems/ems_system_standards.asp or contact one of the following:

The following committee members have voluntarily listed their contact information.			
Name	**Agency**	**Phone Number**	**E-mail Address**
Brian Jacobsen	Davenport Fire Department	563-888-2186	jbj@ci.davenport.ia.us
Craig Keough	Retired Paramedic	563-588-4028	GTFSmustang@yahoo.com
David Luers	Fort Dodge Fire Rescue	515-576-1031	dluers@fortdodgeiowa.org
Dawn Staudt	American Medical Response	641-330-9869	Dawn.Staudt@amr.net
Dr. Dennis I. Mallory	Tama Co EMS Medical Director	641-990-4307	medxm@pcpartner.net
Evelyn Wolfe	Bureau of EMS	319-331-1354	Evelyn.Wolfe@idph.iowa.gov
Frank Prowant	Ankeny Fire Department	515-965-6472	fprowant@ankenyiowa.gov
Jim Mehaffy	Des Moines County EMS Association	319-572-1333	jpmehaffy@gmail.com
Katrina Altenhofen	Bureau of EMS	515-344-1618	katrina.altenhofen@idph.iowa.gov
Kerrie Hull	Calhoun County EMS	712-297-8619	khull@calhouncountyiowa.com
Sheila Frink	Anamosa Area Amb Service	319-721-1411	frinksr@jonesregional.org
Thomas A. Craighton	Franklin General Hospital	641-425-2460	craightt@mercyhealth.com

Iowa Department of Public Health
Division of Acute Disease Prevention and Emergency Response
Bureau of Emergency Medical Services
September 2010

Attachment 24

Iowa Hospital Stroke Triage Designation

Iowa Hospital Stroke Triage Designation

Levels of Stroke Care Capacity:

Updated 02/23/2015

❑ Level 1+: Comprehensive Stroke Center (CSC)

A Level 1+ Comprehensive Stroke Center (CSC) Certification is available only to comprehensive stroke centers in Joint Commission-accredited acute care hospitals and must meet all the criteria for Primary Stroke Certification

- Have dedicated neuro-intensive care unit beds for complex stroke patients that provide neuro-critical care 24 hours a day, seven days a week
- Meet minimum requirements for providing care to patients with a diagnosis of subarachnoid hemorrhage; performing endovascular coiling or surgical clipping procedures for aneurysm; and administering IV tPA
- Use a peer review process to evaluate and monitor the care provided to patients with ischemic stroke and subarachnoid hemorrhage
- Use advanced imaging capabilities.
- Coordinate post hospital care for patients.
- Participate in stroke research.

❑ Level 1: Primary Stroke Center (PSC)

A Level 1 Primary Stroke Center hospital must be certified as a Primary Stroke Center by The Joint Commission or other nationally recognized certification body (such as DNV) and who are required to have the following

- A designated primary contact person (ED director/VP of medical affairs). In Iowa these hospitals also have a designated nurse stroke coordinato
- A stroke team available 24/7
- CT scan of the head completed within 20 minutes of patient arrival and formally read within 45 minutes of order available 24/7
- Laboratory and EKG available within 45 minutes of order 24/7
- Clot dissolving medicine, r-TPA, available 24/7
- Neurosurgery available within 2 hours
- Participation in a stroke registry (such as the Iowa Stroke Registry managed by the U of I College of Public Health
- Other criteria as designated by their certification body

❑ Level 2: Stroke Capable Hospital

A Level 2 Stroke Capable Hospital is required to have all of the following attributes:

- Clot dissolving medicine, tissue plasminogen activator (r-TPA) available 24/7 for administration
- Staff trained in r-TPA administration
- CT scan of head, available for use and analysis within 60 minutes of patient arrival, 24/7
- Laboratory, and electrocardiogram (EKG) available for reading within 60 minutes of ordering, available 24/7
- Agreement(s) and processes are in place for transporting patients to a PSC
- Written stroke policies, procedures, standing acute stroke orders and protocol, and educational requirements are in place that follow the American Stroke Association guideline
- Emergency physician or provider (physician assistant (PA) or nurse practitioner (NP) is available 24/7

❑ Level 3: Triage and Transport (Non-Stroke Capable) Hospital

A Level 3 Triage and Transport hospital is expected to have:

- Written policies, procedures, standing orders, protocols, and appropriate educational requirements that follow the American Stroke Association guidelines for stabilization and transpo
- Hospital assesses, stabilizes (if necessary), transfers stroke patients as soon as possible, and does not provide treatment. Hospital has necessary transport agreements with EM

Hospital	CITY	Level	Contact	Email	Phone	Level 1 Cert. Date	Cert. Expires	Stroke Coordinator	Stroke Team Physician Leaders/Champions
University of Iowa Hospitals and Clinics	Iowa City	1+	Erin Rindels	erin-rindels@uiowa.edu	319-384-7183	5/1/2013	05/1/2015	Erin Rindels	Dr. Harold Adams
Alegent Health Mercy Hospital - CB	Council Bluffs	1	Christine Daley	Christine.Daley@alegent.org	712-328-5967	8/1/2013	8/1/2015	Christine Daley	Joe Hoagbin, MD
Allen Memorial Hospital	Waterloo	1	Jeanette Westendorf	jeanette.westendorf@unitypoint.org	319-235-5060	3/11/2013	3/11/2015	Jeanette Westendorf	Dr. Ameer Almullahassani
Genesis Medical Center - Davenport	Davenport	1	Shannin Young	youngsh@genesishealth.com	563-421-2657	6/6/2014	6/6/2016	Shannin Young	Dr. Rodney Short
Great River Medical Center	West Burlington	1	Susan Fowler	sfowler@grhs.net	319-768-2120	10/24/2014	10/24/2016	Susan Fowler	Dr. Anil Dhuna
Unity Point - Des Moines (IMMC)	Des Moines	1	Laura Juel	laura.juell@unitypoint.org	515-241-5196	8/9/2013	8/9/2015	Lonnie Norgaard	Dr. Calvin Hansen
Jennie Edmundson Hospital	Council Bluffs	1	Peggy Helget	peggy.helget@nmhs.org	712-396-6001	4/1/2013	4/1/2015	Jill Ferguson	Dr. M. Chen
Mary Greeley Medical Center	Ames	1	Sharon Ellrich	ellrich@mgmc.com	515-956-2774	4/1/2014	4/1/2015	Sharon Ellrich	Selden Spencer, MD
Mercy Iowa City	Iowa City	1	Lori Bracken	lori.bracken@mercyic.org	319-530-7734	12/7/2012	12/7/2014	Lori Bracken	Jennifer Stern, MD
Mercy Medical Center-Cedar Rapids	Cedar Rapids	1	Jacklyn Smith	jarsmith@mercycare.org	319-369-4729	2/28/2015	2/28/2016	Jacklyn Smith	Robert Struthers, MD
Mercy Medical Center-Des Moines	Des Moines	1	Terri Hamm	thamm@mercydesmoines.org	515-247-3204	9/17/2013	9/17/2015	Terri Hamm	Dr. Michael Jacoby
Mercy Medical Center-Dubuque	Dubuque	1	Sara Bechen	bechensr@mercyhealth.com	563-589-8101	11/13/2014	11/13/2016	Sara Bechen	Marsha Horwitz, MD
Mercy Medical Center-North Iowa	Mason City	1	Jennifer Thoe	thoej@mercyhealth.com	641-428-7109	8/23/2013	8/23/2015	Jennifer Thoe	Alireza Yarahmadi, MD
Mercy Medical Center-Sioux City	Sioux City	1	Nicole Shea	sheank@mercyhealth.com	712-279-2080	1/16/2013	1/16/2015	Nicole Shea	Dr. Mei He
St. Luke's Health System, Inc.	Sioux City	1	Hope Franken	hope.franken@unitypoint.org	712-279-3437	1/1/2014	1/1/2017	Hope Franken	Dr. Jennifer Pary
St. Luke's Hospital	Cedar Rapids	1	Jennifer Houlihan	jennifer.houlihan@unitypoint.org	319-369-1712	9/24/2014	9/24/2016	Kelly Printy	Dr. Scott Geisler
Trinity Bettendorf	Bettendorf	1	Jodi Dykema	jodi.dykema@unitypoint.org	309-779-3131	4/12/2013	4/12/2015	Paula Maddox	Dr. Deepta Atre-Strand; Dr. Waseem Ahmad
The Finley Hospital	Dubuque	1	Carla Taft	Carla.Taft@unitypoint.org	563-589-2553	12/22/2014	12/22/2016	Caral Taft	Dr. Pamela Westerling
Adair County Memorial Hospital	Greenfield	2	Janet Koster	jkoester@adaircountyhealthsystem.org	641-743-7216				
Alegent Health Community Memorial Hospital	Missouri Valley	2	Darcy Behrendt	darcy.behrendt@alegent.org	715-642-9246				

Iowa Hospital Stroke Triage Designation

Alegent Health Mercy Hospital	Corning	2	Kathleen Peckham	kathleen.peckham@alegent.org	641-322-6273
Audubon County Memorial Hospital	Audubon	2	Holly Kjergaard	kjergaardh@acmhhosp.org	712-563-5251
Avera Holy Family Hospital	Estherville	2	Cathi Scharnberg	cathi.scharnberg@avera.org	712-362-6448
Baum-Harmon Mercy Hospital	Primghar	2	Angie Shilling	shillina@mercyhealth.com	712-957-2300
Boone County Hospital	Boone	2	Sandra Linn	slinn@boonecountyhospital.com	515-433-8154
Buena Vista Regional Medical Center	Storm Lake	2	Michele Kelly	kelly.michele@bvrmc.org	712-213-8604
Burgess Health Center	Onawa	2	Karla Copple	kcopple@burgesshc.org	712-423-9358
Cass County Memorial Hospital	Atlantic	2	Darci Young	youdr@casshealth.org	712-243-3250
Central Community Hospital	Elkader	2	Natalie Shea	shean@mercyhealth.com	563-245-7028
Cherokee Regional Medical Center	Cherokee	2	Connie Mohn	cmohn@cherokeemc.org	712-225-1505
Clarinda Regional Health Center	Clarinda	2	Becky Baldwin	bbaldwin@clarindahealth.com	712-542-8270
Clarke County Hospital	Osceola	2	Melanie Halls	mhalls@clarkehosp.org	641-342-5336
Community Memorial Hospital	Sumner	2	Susie Meyer	smeyer@smhsumner.org	563-578-3275
Covenant Medical Center	Waterloo	2	Paul Franke	paul.franke@wfhc.org	319-830-4947
Dallas County Hospital	Perry	2	Tonya Summerson	tsummerson@dallascohospital.org	515-465-3547
Davis County Hospital	Bloomfield	2	J Kyle DaVolt	jdavolt@daviscountyhospital.org	641-664-7145
Decatur County Hospital	Leon	2	Andi Masters	amasters@d-c-h.org	641-446-2348
Hansen Family Hospital	Iowa Falls	2	Steve Mulford	mulfords@mchsi.com	641-648-7012
Floyd County Medical Center	Charles City	2	Bill Faust	bfaust62@fcmhosp.com	641-228-6830
Floyd Valley Hospital	Le Mars	2	Loretta Myers	Loretta.myers@floydvalleyhospital.org	712-546-3349
Fort Madison Community Hospital	Fort Madison	2	Angela Sloca	asloca@fmchosp.com	319-376-2000
Franklin General Hospital	Hampton	2	Chris Eckhoff	eckhoffc@mercyhealth.com	641-456-5006
Genesis Medical Center, De Witt	De Witt	2	Shannin Young	youngsh@genesishealth.com	563-421-2657
George C. Grape Community Hospital	Hamburg	2	Gloria Mattice	gmattice@grapehospital.com	712-382-1515
Greater Regional Medical Center	Creston	2	Gwen Buck	gwenb@greaterregional.org	641-782-3832
Greene County Medical Center	Jefferson	2	Lori Herrick	lori.herrick@gcmchealth.com	515-386-2114
Grinnell Regional Medical Center	Grinnell	2	Suzanne Cooner	scoone@grmc.us	641-236-2303
Guthrie County Hospital	Guthrie Center	2	Danielle Navarro	daniellen@gcho.org	641-332-3800
Guttenberg Municipal Hospital	Guttenberg	2	Kim Gau	kim.gau@guttenberghospital.org	563-252-1121
Hancock County Memorial Hospital	Britt	2	Laura Zwiefel	zwiefell@mercyhealth.com	641-843-5153
Hawarden Community Hospital	Hawarden	2	Jeanna Negaard	negaardj@mercyhealth.com	712-553-3100
Hegg Memorial Health Center	Rock Valley	2	Glenn Zevenbergen	glenn.zevenbergen@hegghc.org	712-476-8009
Henry County Health Center	Mount Pleasant	2	Ann Corrigan	corrigana@hchc.org	319-385-6782
Horn Memorial Hospital	Ida Grove	2	Marc Augsburger	maugsburger@hornmemorial.org	712-364-3311
Unity Point - Des Moines Lutheran	Des Moines	2	Laura Juel	laura.juell@unitypoint.org	515-241-5196
Unity Point - Des Moines Methodist West	West Des Moines	2	Laura Juel	laura.juell@unitypoint.org	515-241-5196
Iowa Specialty Hospital - Belmond	Belmond	2	Anna Green	anna.green@belmondmed.com	641-444-5571
Jackson County Regional Health Center	Maquoketa	2	Cheryl Curl	cheryl.curl@jcrhc.org	563-652-4044
Jefferson County Health Center	Fairfield	2	Staci Worley	sworley@jeffersoncountyhealthcenter.org	641-472-4111
Jones Regional Medical Center	Anamosa	2	Dee Cook	cookdl@jonesregional.org	319-481-6150
Keokuk Area Hospital	Keokuk	2	Susan Pankey	suep@kah.kahnet.com	319-526-8662
Keokuk County Health Center	Sigourney	2	Wendy Stuhr	wstuhr@kchc.net	641-622-1120
Knoxville Hospital & Clinics	Knoxville	2	Jane Kruger	jkruger@knowvillehospital.org	641-842-1592
Kossuth Regional Health Center	Algona	2	Dar Elbert	elbertd@mercyhealth.com	515-295-4601
Lakes Regional Healthcare	Spirit Lake	2	Connie Lange	clange@lakeshealth.org	712-336-8797
Loring Hospital	Sac City	2	Linda Brown	lbrown@loringhosp.org	712-662-7105
Lucas County Health Center	Chariton	2	Patty Pottorff	ppottorff@lchcia.com	641-774-3211
Madison County Health Care System	Winterset	2	Cindy Frank	cfrank@madisonhealth.com	515-462-2373
Mahaska Health Partnership	Oskaloosa	2	Andrea Hagist	ahagist@mahaskahealth.org	641-672-3206
Manning Regional Healthcare Center	Manning	2	Leigh Davis	leigh.davis@mrhcia.com	712-655-2072
Marengo Memorial Hospital	Marengo	2	Lisa Eckholm	leckholm@marengohospital.org	319-642-8192
Marshalltown Medical and Surgical Center	Marshalltown	2	Mary Schreurs	mschreurs@marshmed.com	641-844-6205
Mercy Medical Center - West Lakes	West Des Moines	2	Terri Hamm	thamm@mercydesmoines.org	515-358-0048
Mercy Medical Center-Centerville	Centerville	2	Mary Lou Sales	msales@mercydesmoines.org	641-437-3482
Mercy Medical Center-Clinton	Clinton	2	Amy Berentes	berentea@mercyhealth.com	563-244-5609
Mercy Medical Center-New Hampton	New Hampton	2	Sherrie Laubenthal	laubensl@mercyhealth.com	641-394-1634
Mitchell County Regional Health Center	Osage	2	Judy Brown	brownjan@mercyhealth.com	641-732-6048
Montgomery County Memorial Hospital	Red Oak	2	Holly Crowell	hcrowell@mcmh.org	712-623-7144

Iowa Hospital Stroke Triage Designation

Myrtue Medical Center	Harlan	2	Karen Buman	kbuman@myrtuemedical.org	712-755-4439
Orange City Area Health System	Orange City	2	Laurie Gebauer	gebauerl@ochealthsystem.org	712-737-5358
Osceola Community Hospital, Inc.	Sibley	2	Julie Schroder	julie.schroder@avera.org	712-754-2574
Palmer Lutheran Health Center, Inc.	West Union	2	Debra Kelly	dckelly@palmerlutheran.org	563-422-3811
Palo Alto County Health System	Emmetsburg	2	Jo Ann Higgins	higginsj@mercyhealth.com	712-852-5415
Regional Medical Center	Manchester	2	Heather Ries	heather.ries@regmedctr.org	563-927-7531
Ringgold County Hospital	Mount Ayr	2	Kathleen Schuster	kschuster@rchmtayr.org	641-464-3226
Sanford Hospital Rock Rapids	Rock Rapids	2	Joni De Kok, CNO	joni.dekok@sanfordhealth.org	712-324-6330
Sanford Medical Center Sheldon	Sheldon	2	Shantel Van Gelder	Shantel.Vangelder@sanfordhealth.org	712-324-6330
Shenandoah Medical Center	Shenandoah	2	Tammy Franks	tfranks@smchospital.com	712-246-7437
Sioux Center Community Hospital/Health Center	Sioux Center	2	Marilyn Ver Meer	marilyn.vermeer@schospital.org	712-722-8218
Skiff Medical Center	Newton	2	Vicky Norrish	vnorrish@skiffmed.com	641-791-4871
Spencer Hospital	Spencer	2	John Hill	jhill@spencerhospital.org	712-264-6445
St. Anthony Regional Hospital	Carroll	2	Lynda D.	lynda@stanthonyhospital.org	712-794-5285
Stewart Memorial Community Hospital	Lake City	2	Cynthia Carstens	ccarstens@stewartmemorial.org	712-464-4218
Story County Medical Center	Nevada	2	Lisa Whitaker	lwhitaker@storymedical.org	515-382-7726
Trinity Muscatine	Muscatine	2	Pamela Askew	Pamela.askew@trinitymuscatine.org	563-264-9303
Trinity Regional Medical Center	Fort Dodge	2	Daphne Willwerth	willweda@ihs.org	515-574-6422
Van Buren County Hospital	Keosauqua	2	Maureen Sedlacek	maureen.sedlacek@vbch.org	319-293-3171
Van Diest Medical Center	Webster City	2	Michelle Stapp	mstapp@hamiltonhospital.com	515-832-7710
Veterans Memorial Hospital	Waukon	2	Diane Butikofer	dbutikofer@vmhospital.org	563-568-3411
Virginia Gay Hospital	Vinton	2	Tina Eden	teden@vghinc.com	319-472-6276
Washington County Hospital & Clinics	Washington	2	Brandice Armstrong	barmstrong@wchc.org	319-863-3969
Waverly Health Center	Waverly	2	Rhonda DeBuhr	rdebuhr@waverlyhealthcenter.org	319-483-4017
Wayne County Hospital	Corydon	2	Cody Babbitt	cbabbitt@mercynetworkcia.org	641-872-2260
Winneshiek Medical Center	Decorah	2	J Kevin Rockwell	rockwellj@winmedical.org	563-387-3015
Broadlawns Medical Center	Des Moines	3	Sherry Olson	sdolson@broadlawns.org	515-282-2427
Buchanan County Health Center	Independence	3	Julie Sprocell	jsprocell@bchealth.info	319-332-0899
Crawford County Memorial Hospital	Denison	3	Martin Bornhoft	mbornhoft@ccmhia.com	712-265-2548
Grundy County Memorial Hospital	Grundy Center	3	JoDee Knox	jodee.knox@unitypoint.org	319-824-4139
Humboldt County Memorial Hospital	Humboldt	3	Julie Carlson	Juliec@humboldthospital.org	515-332-4200
Monroe County Hospital	Albia	3	Greg Paris	gparis@mchalbia.com	641-932-1755
Pella Regional Health Center	Pella	3	Yvonne O'Brien	yobrien@pellahealth.org	641-628-6629
Pocahontas Community Hospital	Pocahontas	3	Erin Peterson	epeterson@pocahontashospital.org	712-335-5216
Sartori Memorial Hospital, Inc.	Cedar Falls	3	Paul Franke	paul.franke@wfhc.org	319-830-4947
VA Central Iowa Health Care System	Des Moines	3			
VA Iowa City Health Care System	Iowa City	3			
Iowa Specialty Hospital - Clarion	Clarion	Did not report			
Mercy Hospital of Franciscan Sisters	Oelwein	Did not report			
Mercy Medical Center-Dyersville	Dyersville	Did not report			
Ottumwa Regional Health Center	Ottumwa	Did not report		kthompson@orhc.com	
Regional Health Services of Howard Co.	Cresco	Did not report			

Attachment 25

EMSAC Membership List

Iowa Department of Public Health

BUREAU OF EMERGENCY AND TRAUMA SERVICES

Iowa Emergency Medical Services Advisory Council Members – October 2014

Name	County of Residence	Organization	Year First Appointed	Term Ends June 30
Janis Adams, RN	Dallas	Iowa Nurses Association	2003	2015
Thomas Benzoni, MD	Polk	Iowa Medical Society	2009	2015
Christopher Buresh, MD	Johnson	University of Iowa Hospitals and Clinics	2007	2015
OPEN		American Academy of Emergency Medicine, IA Chapter		2015
Jason C. Griffin, Paramedic	Louisa	At-Large Volunteer EMS Provider	2012	2015
Ellen Hagen, EMT	Hamilton	Iowa Firefighters Association	2012	2015
Marianka Pille, MD	Polk	American Academy of Pediatrics, Iowa Chapter	2012	2015
Traci Smith, Paramedic	Poweshiek	At-Large Volunteer EMS Provider	2012	2015
Daphne Willwerth	Webster	Iowa Hospital Association	2009	2015
Jamey Robinson, Paramedic	Mahaska	Iowa State Association of Counties	2013	2016
Cherri Fuehring, Paramedic	Lancaster	Iowa EMS Training Program Association	2010	2016
Amy Kumagai, DO	Polk	Iowa Osteopathic Medical Association	2006	2016
Chairperson Jeffrey J. Messerole, Paramedic	**Dickinson**	**Iowa EMS Association**	**1998**	**2016**
Tina Patterson, PA-C	Warren	Iowa Physician Assistant Society	2004	2016
Joshua Stilley, MD	Johnson	American College of Emergency Physicians, Iowa Chapter	2013	2016
Jenny Butler, MD	Jones	Iowa Academy of Family Physicians	2014	2017
Tammy Fleshner, EMT-I	Butler	Iowa EMS Association (volunteer)	2009	2017
Linda Frederiksen, Paramedic	Scott	Iowa EMS Association (private service)	2011	2017
Janeen Justice, Paramedic	Johnson	Iowa Professional Firefighters	2006	2017
Mark McCurdy, Paramedic	Lucas	Iowa Firefighters Association	2005	2017

Attachment 26

QASP Membership List

QASP Subcommittee Members

March 25, 2015

Urban ALS	Jeff Anderson
EMS Education	Cheryl Blazek
Flight Program	Dennis Cochran
Urban BLS	Colleen Dickerson
Rural ALS	Kerri Hull
Hospital-Based Provider	Jeff Kurth
EMS Educator	Lee Ridge
Service Director	Steve Spenler
EMSAC	Josh Stilley, MD (chair)
Rural BLS	Angela Buskohl

Alternate Members

Urban ALS	Chris Perrin
EMS Education	Open
Flight Program	Bryan Williams
Urban BLS	Brian Helland
Rural ALS	Open
Hospital-Based Provider	Bruce Musgrave
EMS Educator	Jeff Messerole
Service Director	Open
EMSAC	Jason Griffin
Rural BLS	Open

Attachment 27

STRCC Charter

STRCC
CHARTER

Iowa Statewide Traffic Records Coordinating Committee

December 2011

History

Background: Iowa has had a multidisciplinary statewide traffic records committee for communication, planning, and coordination since June 1994. Originally called the Strategic Planning Project (StraPP), it later took the name Statewide Traffic Records Advisory Committee (STRAC). This committee met quarterly, with additional ad hoc meetings. The Iowa Safety Management System Coordination Committee (SMSCC) formed in a similar manner in February 1995 and enhanced general highway safety coordination, as STRAC handled safety data coordination.

Executive guidance: StraPP was set up with a working committee and a Guidance Team of appropriate executives who received copies of all documents and attended meetings either occasionally or regularly. When members of the Guidance Team attended the working committee meetings, they worked along with other participants.

Program history: Iowa was the first state to be awarded a NHTSA grant for strategic planning in 1994. The first strategic plan was completed in 1995. The strategic plan was updated periodically during Section 411 funding, and Iowa received implementation grants for each year of the Section 411 program. STRAC also sponsored and organized statewide traffic records conferences, similar to the national Traffic Records Forums, in 1994 and 2001.

Creation of this Charter: Given the requirements of the SAFETEA-LU "Section 408 Program," it was decided to formalize STRAC with a Charter supported by letters of support from key executives, renewing the Guidance Team as the "second tier" of a two-tiered committee.

Name change: STRAC had essentially functioned as a coordinating committee so it was decided to replace "advisory" with "coordinating" in the committee's name. Therefore the creation of STRCC; the Statewide Traffic Records Coordinating Committee.

Vision, Mission, and Goal

VISION: The Vision of STRCC is to maximize traffic safety problem identification, planning, evaluation, and decision-making through coordination and cooperation at all levels of government and by all safety entities in communities through access to quality safety data. The data system should be sustainable, provide quality service for a reasonable investment, and achieve an effective balance of limited resources between data systems and the highway safety programs they serve.

MISSION: The Mission of STRCC is to develop and improve the "virtual" statewide traffic records system and all of its independent real components.

Central to this mission are the advancement of electronic data capture, appropriate integration of data, effective utilization of the data through the Highway Safety GIS and other means of data dissemination, and education of data collectors and users.

The Mission will be accomplished by incorporating advanced technology, wise use of resources, open communication opportunities by all members, a spirit of cooperation and teamwork, and future planning. The data driven process should ensure that all opportunities to improve highway safety are identified and considered for implementation. Continued evaluation shall be conducted to facilitate implementation and strategic development of state data systems and projects.

GOAL: The goal of STRCC is to ensure that complete, accurate, and timely traffic safety data are collected, analyzed, and made available for decision-making at the state, local, and national levels **to reduce crashes, deaths, and injuries on Iowa streets and highways. Data should be made available in a concise manner for the end-user.**

I. State Traffic Records System Definition

"A traffic records system is generally defined as a virtual system of independent real systems which collectively form the information base for the management of the highway and traffic safety activities of a state and its local subdivisions." (Iowa Traffic Records Assessment Report, 2006, page 9.)

STRCC's unique responsibility is to coordinate these independent real systems into a virtual system effective in saving lives and mitigating the harm of traffic crashes.

Organizational Structure and Function

Two-tiered Committee: The committee has two tiers; the Guidance Team and STRCC
The Guidance Team and STRCC shall be responsible for developing, maintaining and tracking accomplishments related to data projects as related to the State's Strategic Plan.

I. Guidance Team: The executive level of STRCC is composed of agency department management who set the vision and mission for the remaining STRCC membership. The four-person guidance team is comprised by the following representatives:

- Bureau Chief, Governor's Traffic Safety Bureau, Iowa Department of Public Safety
- Director, Office of Traffic and Safety, Iowa Department of Transportation
- Director, Office of Driver Services, Iowa Department of Transportation
- Bureau Chief, Bureau of Emergency Medical Services, Iowa Department of Public Health

The team meets with members and attends STRCC meetings. The Guidance Team approves changes to the Charter, reviews, offers input and approves traffic data projects and any changes to the Guidance Team membership. The STRCC Co-Chairs will provide, in writing, a summary of quarterly STRCC meetings to the Guidance Team. Guidance Team members will provide input to

STRCC regarding the commitment and obligation of the state agencies which they represent. Guidance Team members often are, by their own choice, participants in the full committee, ensuring communication between the two tiers. This has been the case throughout the committee's twelve-year history.

II. STRCC Membership: Members include executives and professional staff, generalists as well as specialists. Leadership and innovation are cultivated within STRCC so that all members are, or have the opportunity to become, star performers in their areas of expertise. An egalitarian spirit is pervasive. Members include representatives from each of the traffic safety records systems (crash, roadway, driver, vehicle, citation/adjudication, and injury surveillance) and include safety professionals involved in data collection, data management, and data applications.

Co-Chairs of STRCC: One Co-Chair is a member or designee of the Governor's Traffic Safety Bureau and also serves as the single point of contact for traffic records in Iowa. The Second Co-Chair is a member of a state agency directly involved in the maintenance or analysis of state traffic records.

The Co-Chairs are responsible for the ongoing institutional "health" of STRCC. They set meeting dates and agendas with input of STRCC membership, communicate with the membership, arrange meeting facilities, preside over meetings, organize activities including strategic planning, and sustain the multidisciplinary, multi-agency nature of the membership. The Co-Chairs are responsible for the preparation and submittal of annual progress reports associated with the 408 program. While not the only members who draft documents, plans, and grant proposals, they create or oversee those that are the specific responsibility of STRCC.

The Co-Chairs must be aware of what is taking place in Iowa regarding traffic safety data, reach out to stakeholders, listen and learn to maintain institutional culture. They must conduct STRCC with an approach of inclusiveness rather than exclusiveness. Regarding communications and networking outside of Iowa, the Co-Chairs share with other STRCC members the responsibility to remain aware of developments in traffic records nationwide, and to share this information with all Iowa STRCC members.

The Co-Chairs promote direct involvement and attendance in these professional activities by other Iowa STRCC members, supported by the Guidance Team for STRCC. When added to the participation and outreach conducted for TraCS. These efforts enable numerous Iowans to grow professionally and to experience an unprecedented level of exposure to their state and national traffic records and safety data counterparts and vice versa.

Data Quality and Analysis Coordinator: A member of STRCC serves as a focal point for data quality and analysis issues. The responsibilities of the Data Quality and Analysis Coordinator are to serve as the resident expert on these matters, assisting the Co-Chairs and STRCC Membership to understand the degree of current quality, how quality may be improved or threatened by future developments, and what analysis methodologies are appropriate for Iowa safety data.

Liaisons: STRCC liaisons participate in the same manner as other members, including having

Voting rights. Liaisons shall abstain from voting if there is a potential conflict of interest.

STRCC has the following liaison members:

- Iowa Traffic Safety Alliance
- FHWA liaison
- FMCSA liaison
- NHTSA liaison
- One or more University liaisons

Consultants, Independent Contractors and Friends of STRCC: Persons interested in STRCC meeting agendas, meeting notes, and other activities of the committee are welcomed to be placed on the email address list for STRCC. Friends are welcomed at meetings, and Members are encouraged to bring guests; prior notice is appreciated.

Meetings: Meetings are typically held once per calendar quarter with additional meetings called as needed. Attendance rosters, agendas, meeting minutes and other supporting meeting documentation shall be maintained by STRCC Co-Chairs.

STRCC role and functions: The STRCC has the following attributes and functions:

a) Includes representatives from highway safety, highway infrastructure, law enforcement and adjudication, public health, injury control and commercial vehicle agencies and organizations;
b) Has the authority to review any of the State's highway safety data and traffic records systems and to review changes to such systems before the changes are implemented;
c) Provide a forum for the discussion of the highway safety data and traffic records issues and report on any such issues to the agencies and organization in the State that create, maintain and use highway safety data and traffic records;
d) Consider and coordinate the views of organizations in the State that are involved in the administration, collection and use of the highway safety data and traffic records system;
e) Represent the interests of the agencies and organizations within the traffic records system to outside organizations; and
f) Review and evaluate new technologies to keep the highway safety data and traffic records systems up-to-date.

State Traffic Records Assessments: In addition, the STRCC is responsible for the state-based work involved in periodic Traffic Records Assessments (logistics, questionnaires, scheduling and participating in interviews, follow-up, etc.) Iowa had NHTSA- sponsored assessments completed in 1994, 2005, and 2011. Successful assessments require the participation of STRCC membership.
STRCC is responsible for creating a strategic plan for the statewide traffic records system. It periodically conducts strategic planning meetings allowing for extensive study and participation by its members, utilizing the Traffic Records Assessment findings, providing for evaluation of Assessment recommendations, and culminating in a strategic plan document. Included are the state agencies who are custodial agents for the major datasets (crash, roadway, driver, vehicle, enforcement and adjudication, and injury control) of the traffic records systems, and the data

collectors and data users at all levels of Iowa government. By performing the work involved in strategic planning, members have buy-in to the product.

STRCC has played a key role in prioritizing candidate projects for funding across several funding sources, including federal and state safety funds.